UNITED
NATIONS

E

Economic and Social Council

Distr.
GENERAL

E/CONF.84/PC/7
17 March 1993

ORIGINAL: ENGLISH

PREPARATORY COMMITTEE FOR THE
INTERNATIONAL CONFERENCE ON
POPULATION AND DEVELOPMENT
Second session
10-21 May 1993
Item 4 of the provisional agenda*

PREPARATIONS FOR THE CONFERENCE

Recommendations of the Expert Group Meeting on Family Planning, Health and Family Well-being

Report of the Secretary-General of the Conference

SUMMARY

In response to Economic and Social Council resolution 1991/93, the Expert Group Meeting on Family Planning, Health and Family Well-being was convened in Bangalore, India, from 26 to 30 October 1992 as part of the preparations for the International Conference on Population and Development to be held in 1994. The findings of the Expert Group are presented in this report for consideration in the context of the review and appraisal of the World Population Plan of Action by the Preparatory Committee for the Conference. The Expert Group examined the linkages between family planning, health and family well-being and emphasized the need to place family planning in the wider context of quality of life of women and children, and health and welfare of the family and to shift the focus of family planning programmes from demographic targets to individual needs. The deliberations had as their objectives to contribute to the review and appraisal of the progress made in attaining the objectives, goals and recommendations of the Plan of Action, to identify the obstacles encountered and to adopt a set of recommendations for the next decade in order to support couples and individuals in making informed and voluntary choices about the timing, number and spacing of children, through family planning programmes.

* E/CONF.84/PC/3/Rev.1.

CONTENTS

	Paragraphs	Page
INTRODUCTION	1 - 7	3
A. Background	1 - 3	3
B. Opening statements	4 - 7	3
I. SUMMARY OF THE PAPERS AND DISCUSSION	8 - 35	5
A. Society and family planning	11 - 13	6
B. Review of existing family planning programmes and lessons learned	14 - 15	7
C. Issues related to the implementation of family planning programmes	16 - 25	8
D. Family planning and health	26 - 28	11
E. Family planning and family well-being	29 - 31	13
F. Future directions: people's involvement in family planning programmes	32 - 35	14
II. RECOMMENDATIONS	36 - 46	17
A. Preamble	36 - 46	17
B. Recommendations		19

INTRODUCTION

A. Background

1. The Economic and Social Council, in its resolution 1991/93 of 26 July 1991, decided to convene an International Conference on Population and Development under the auspices of the United Nations and decided that the main theme of the Conference would be population, sustained economic growth and sustainable development. The Council authorized the Secretary-General of the Conference to convene six expert group meetings as part of the preparatory work.

2. Pursuant to that resolution, the Secretary-General of the Conference convened the Expert Group Meeting on Family Planning, Health and Family Well-being in Bangalore, India, from 26 to 30 October 1992. The Meeting was organized by the Population Division of the Department of Economic and Social Development of the United Nations Secretariat in consultation with the United Nations Population Fund (UNFPA). The participants, representing different geographical regions, scientific disciplines and institutions, included 18 experts invited by the Secretary-General of the Conference in their personal capacities; representatives of the United Nations Office at Vienna, the United Nations Children's Fund (UNICEF), the five regional commissions, the United Nations Educational, Scientific and Cultural Organization (UNESCO), the World Health Organization (WHO) and the World Bank. Also represented were the following non-governmental organizations: International Institute for Rural Reconstruction (IIRR); International Planned Parenthood Federation (IPPF); International Union for the Scientific Study of Population (IUSSP); Population Council; Center for Development and Population Activities; Population Institute; Program for Appropriate Technology in Health (PATH); Association for Voluntary Surgical Contraception (AVSC); Family Health International (FHI); Institute of Resource Development (IRD)/Macro Systems; Japanese Organization for International Cooperation in Family Planning (JOICFP); Pathfinder International; Population Crisis Committee; and Rockefeller Foundation.

3. As a basis for discussion, the 16 experts had prepared papers on the agenda items. The views expressed by the experts were their own and did not necessarily represent the policies of their Governments or organizations. The Department of Economic and Social Development prepared a background paper entitled "Key issues in family planning, health and family well-being in the 1990s and beyond". UNFPA contributed a paper on future contraceptive requirements and logistics management needs. Discussion notes were provided by the United Nations Office at Vienna, the regional commissions and a number of specialized agencies and non-governmental organizations.

B. Opening statements

4. Opening statements were made by Ms. D. K. Thara Devi Siddartha, Union Minister of State for Health and Family Welfare of the Government of India; Dr. Nafis Sadik, Secretary-General of the International Conference on Population and Development; and Mr. Shunichi Inoue, Deputy Secretary-General of the Conference.

5. In her opening remarks, Dr. Sadik noted that India provided an ideal setting for the Meeting because India was the first developing country in the world to have a national population programme and had continued its commitment to planned population growth and voluntary family planning since 1951. She also commended the efforts of the Government of India in placing family planning in the wider context of health and family welfare and agreed with the national strategy which emphasized the development of human resources rather than controlling human numbers. Ms. Thara Devi Siddartha reaffirmed the position of the Government of India that, for the future well-being of the country, the highest priority had been accorded to population stabilization efforts. In this regard, she noted that fertility behaviour could not be understood in isolation without reference to the socio-cultural context, nor could family planning policies be pursued successfully without promoting conducive socio-economic conditions such as female literacy, the general quality of life, reproductive health and family well-being. She further noted that there was a need to shift the emphasis from quantitative to qualitative assessment of the population, which would require a holistic approach to population control. Women's total health must become the central concern of planning. When a woman was given the opportunity of choosing her time of conception, the size of her family and the time period between births, very large benefits were likely to accrue.

6. Dr. Sadik emphasized the need to place family planning in a wider context of quality of life of women and children, health and family welfare. She also stressed the need to enhance the status of women, which was crucial for achieving sustainable development. To realize this goal, women must have equal access to education and equal participation in social, economic, cultural and political life. These considerations implied the need for universal access to a wide range of safe, affordable and effective contraceptive alternatives to meet the vast unmet demand for family planning. Considering the growing problem of adolescent fertility, she stressed the necessity of preventing teenage pregnancy and removing the widespread ignorance among young people of the risks of unprotected sexual activity. She emphasized the need to involve men in family planning and to provide them with necessary information, education and encouragement to take greater responsibility in contraceptive practice and responsible parenthood. She noted that family planning programmes could contribute substantially to the reduction of maternal mortality and the improvement of the reproductive health of women. She hoped that strategies for the prevention of acquired immune deficiency syndrome (AIDS) could be found within the framework of family planning and the Safe Motherhood Initiative, with particular focus on the needs of women and adolescents. She stressed the importance of a high quality of services for expanding the levels of acceptance and continuation of contraceptive practices. She noted that special efforts were needed to bring high-quality family planning services to vulnerable and/or under-served sections of the population, including people in minority communities, rural areas and urban slums. To improve the quality of care, clients must be given a wide choice of contraceptive methods and must be treated with dignity and respect by well-trained service providers. She stressed that more research, development and training were necessary to widen the range and improve the quality of available contraceptive methods. It was also necessary to ensure that contraceptive supplies were available at the right time and place and in the right quantity. She underscored the necessity of directly involving local communities to ascertain the family planning needs of communities with widely different backgrounds and suggested that this "people-centred approach"

might encourage clients to share the cost of services. She observed that the pool of international resources for development was not growing as fast as the demand for resources. It was therefore essential to increase coordination and collaboration between national family planning programmes, non-governmental organizations, the private sector and international organizations.

7. Mr. Inoue, while enumerating the notable progress made in family planning practice in the past decade, noted that the current level of fertility and the rate of population growth in many developing countries were still too high and incompatible with the goal of achieving sound social and economic development. He stressed the importance of women's choice on the number of children or family size and matching of individual fertility goals to national goals. He suggested that family planning should be seen as a means to improve the health and well-being of the family.

I. SUMMARY OF THE PAPERS AND DISCUSSION

8. In addition to a more general exchange of views regarding the key issues in family planning, health and family well-being in the 1990s and beyond, and the linkages between family planning, health and family well-being, the Expert Group devoted particular attention to the following areas: society and family planning; review of existing family planning programmes and lessons learned; issues relating to the implementation of family planning programmes (quality of services and human resources development, unreached population groups, adolescent fertility, diffusion of innovative activities, community-based distribution systems and social marketing of contraceptives, and future contraceptive requirements and logistics management needs); family planning and health (safe motherhood and child survival: the interdependence of services; family planning, sexually transmitted diseases and AIDS); family planning and family well-being (family size, structure and child development; fertility decline and family support system); people's involvement in family planning programmes (community participation in family planning; cost of contraceptive supplies and services and cost-sharing; contraceptive research and development; re-examination of the roles of Governments, non-governmental organizations and the private sector in family planning). Both developed and developing country situations were considered, although the latter dominated the discussion.

9. In formulating recommendations, the Expert Group focused on identifying practical measures that could be taken to broaden the scope of family planning programmes in order to make them more effective and efficient, that would help to meet the unmet reproductive health needs of women, and that would also have desirable effects on the status of women and the health and well-being of the family. The Expert Group also reviewed the state of knowledge about the topics mentioned above and made recommendations regarding the need for research and data collection.

10. The contributions of family planning towards improving the quality of life of the population, particularly the health and well-being of the family, have been the focus of increasing international attention in a variety of contexts, including human rights and equity and participation of women in the process of social and economic development. There is currently an array of international declarations and agreements concerning the roles of family planning in improving

the status of women, the health of mothers and children, and the environment. These include the World Population Plan of Action (1974) and the Recommendations for Further Implementation of the Plan (1984), the Nairobi Forward-looking Strategies for the Advancement of Women (1985), the Safe Motherhood Initiative (1987) and the Amsterdam Declaration on a Better Life for Future Generations (1989). The Expert Group noted that international declarations and agreements provided necessary support and sound guidelines for charting the future course of action and urged that necessary action be taken in implementing them.

A. Society and family planning

11. The Meeting considered the general issues of fertility transition, women's status and sociocultural milieu and how women's status had affected the practice of family planning. The status of women needed to be examined in relation to the social organizations and cultural contexts which vary from society to society; hence, it remained an elusive concept, further complicated by varied definitions of status such as prestige, power, autonomy and rights. It was suggested that the identification of factors underlying gender inequality might help in understanding fertility behaviour, because fertility goals were likely to depend on the extent to which women rely on their male kin and sons for status and security. It was recommended that removal of gender inequalities would enhance the status of women, which, in turn, would have a positive impact on family planning. The Meeting further considered the reverse side of the relationship, namely the effect of reduced fertility on women's status. The reduction of time spent in reproduction and child care allowed women to expand their participation in the public sphere. It followed that family planning was a major avenue to improve women's status by providing greater control over reproductive decisions. It also provided control over fate and thus empowered women. These independent effects of family planning at microstructural levels needed to be emphasized.

12. The Meeting also considered issues relating to fertility transition and socio-economic development, including the status of women and associated policy questions on investments in social sectors. More specifically, the questions raised here were: What social sector investments are likely to strengthen the impact of family planning and reproductive health services? and How can the design of services be better tailored to the socio-economic structure in which they all expected to be effective? The Meeting was of the view that social development might be contributing more to fertility decline than to economic development. The Meeting emphasized, however, that there was no point in presenting socio-economic development and family planning programmes as competitive or alternative approaches. Changes in fertility behaviour, stemming from socio-economic development and increased acceptance of family planning, should be seen as a gradual process with synergistic effects. It would, therefore, be productive to identify the linkages between social change, family planning programme effort and reproductive behaviour. One such linkage was established through research on "proximate" determinants of fertility, where effects of socio-economic factors on fertility were usually seen to be mediated through proximate factors such as use of contraception and rising age at marriage.

13. A second line of inquiry that had helped to clarify the understanding of synergies between socio-economic forces and programmatic variables in accelerating fertility decline was the series of cross-national studies. These studies showed that fertility declined most rapidly in countries with high scores with both sets of indicators. These synergies were also found in country-level studies of fertility transitions now occurring in many developing countries, particularly in Asia and Latin America. These studies illustrated that, even in ostensibly unfavourable conditions, fertility decline could be accelerated by programme efforts that were sensitive to local conditions, responsive to community needs and designed to encourage social change. For instance in Bangladesh, the recruitment of female outreach workers had contributed to changes in the status of women. In the light of recent empirical evidence, the Meeting made an important assertion that the progress of family planning programmes was not dependent upon levels of socio-economic development, because programmes were more than the mere supply of contraceptives; they had evolved to respond to the particular needs of a particular society. Thus, two decades of programme experience had shown that the linkages between programme effort and socio-economic setting involved a variety of synergies that needed to be better understood and strengthened in order to guide social sector investments in health and family planning, female education and other factors that improve the status of women.

B. Review of existing family planning programmes and lessons learned

14. A comprehensive overview of the family planning situations in various regions of the developing world was presented at the Meeting. This overview highlighted the process of socio-economic changes affecting different parts of the world in terms of gross national product (GNP) per capita, literacy, primary and secondary school enrolment, percentage of men in the non-agricultural labour force, life expectancy, total fertility rate and infant mortality rate. Particular attention was paid to the current situation in the least developed countries. In most regions, there had been socio-economic progress, notably in East and South-East Asia, with simultaneous progress in the development of family planning programme efforts. It was apparent that, in general, programme improvements had not matched the progress in socio-economic development. Nevertheless, there was a positive relationship between improvement in socio-economic conditions and programme strength. There were also exceptions to these relationships, where there had not been much socio-economic improvement but programmes had become stronger and where fertility decline was in progress (for example, Bangladesh and Botswana). On the other hand, notable changes had taken place in socio-economic conditions among the Arab States; yet fertility decline had not been observed, owing, in part, to the absence of organized family planning programmes, with the exceptions of Algeria, Egypt, Morocco and Tunisia. There is a third set of countries (sub-Saharan Africa) where socio-economic conditions had not changed to any appreciable extent nor had programme efforts gained much strength. In most of these regions, fertility level still remained high and contraceptive practice very low. The primary impetus to the adoption of policies to reduce fertility in Latin America had come from the medical profession, which was greatly concerned about the large number of septic abortions. Governments were slow to react; hence, the private sector and

non-governmental organizations had played an important role in supporting the cause of family planning, and also in the provision of services. Latin America, in general, with better socio-economic conditions compared to the developing countries in other regions, showed a relatively high contraceptive prevalence throughout most of the region.

15. The general conclusions drawn from the above broad assessment were that family planning programmes could have an independent effect on fertility rates and their effectiveness was greatly enhanced when socio-economic development occurred simultaneously. Organized family planning programmes and socio-economic development together produce synergistic effects on fertility. In this overview, several important programme characteristics were identified as crucial for the success of family planning programmes. A selected few of them drew the attention of the Meeting more than the others. These were: political commitment and strong leadership, the adoption of a client's perspective, contraceptive availability/accessibility, quality of services, wide choice of methods, modes of delivery of services and information, education and communication campaigns. It was said that political commitment was fundamental to the success of the programmes, but its importance diminished as socio-economic conditions improved. In high socio-economic settings, favourable to low fertility, political commitment was necessary only to remove barriers to family planning programmes. It was also noted that political commitment in the developed countries was necessary to ensure sufficient international financial aid. Concern was expressed at the Meeting that the present design and ethos of many family planning programmes emphasized quantitative aspects of achievement at the cost of quality of care and clients' needs and preferences, and therefore women's reproductive health needs were neglected. To raise contraceptive prevalence further, it would be necessary to increase the participation of women in the decision-making process for programme design and implementation. Furthermore, women should be given the choice of meeting their reproductive goals. It was noted that, as abortion played important roles in maternal mortality and fertility decline, the question of abortion could not be put aside.

C. Issues related to the implementation of family planning programmes

16. The Meeting again stressed the need to improve the quality of services at all stages of programme development. The success of family planning programmes had been usually evaluated on the basis of their quantitative impact on fertility. Under these circumstances, there had been overwhelming concern for quantitative achievements: number of clients, births averted and so on. The issue of quality of services had become all the more important now that it had been recognized that improvement in the quality of services would result in an increase of contraceptive use and a subsequent reduction in fertility. The Meeting, therefore, emphasized that a shift to quality services had emerged as an important area of programme development in the 1990s. It was often claimed that calls for greater quality of services could not be met owing to a lack of resources, but the Meeting observed that the critical bottleneck with respect to quality was not resources but a lack of commitment on the part of the top management. A significant part of this lack of commitment could be traced to the difficulties in defining the quality of services and the absence of readily

measurable indicators of quality. The Expert Group then considered various elements of quality of service: choice of contraceptive methods; information given to clients; technical competence; client/provider relations; mechanisms to encourage continuity; and appropriate constellation of services. These six elements were regarded as fundamental but their relative importance and precise form should be adjusted according to specific country situation. A first, important step in the right direction would be to shift the focus from demographic targets to individual needs. With regard to measures for improvement of quality of services, the Expert Group also emphasized the necessity of human resources development, with provision for continuous supervision and a management style that emphasized enhancement of skills rather than punitive measures. Quality of care and human resources development were generally linked.

17. The Expert Group noted that, although levels of contraceptive use had increased substantially throughout the developing countries in the past decade, there remained many sectors of the population, such as minorities, remote rural areas or adolescents, that had not been reached by programmes because of resource constraints and other reasons. More importantly, men represented the "forgotten 50 per cent of family planning clientele". The critical constraint in reaching men was the providers, not men themselves. Men had not received the attention they deserved. Empirical evidence suggested that men had played a major role both as facilitators and as inhibitors for female contraceptive use. The role of men in family planning was becoming increasingly important in the context of raising contraceptive prevalence and further reduction of the level of fertility. Men, when approached, were often willing to support family planning practice, either by practising themselves or by helping their wives to practise. Therefore, men should be approached with more assertive motivational campaigns that stress the sharing of contraceptive responsibility, choices of contraceptive methods and parenthood responsibilities. This new direction implied more research on male methods of contraception and male attitudes.

18. A growing concern was expressed in the Meeting about the necessity of reaching the minority populations with family planning services. The Meeting recognized that the strategies that had succeeded in increasing contraceptive use in the majority population might not have much effect on these special groups. Family planning providers needed to understand better the barriers to family planning acceptance in these communities before undertaking vigorous promotional activities. Community and religious leaders and husbands might be helpful in overcoming the barriers to contraceptive use in these communities.

19. Another important category that had not been reached sufficiently constituted the people in remote areas: a neglect that had given rise to pronounced regional differences in contraceptive use. The Expert Group noted that every effort should be made to reach these areas in order to remove regional disparities. The Group also recognized the special unmet need of young couples, within or outside marriage, to have access to family planning services. Despite Governments' declared intentions, access to appropriate services by this particular group remained problematic. Furthermore, the need for family planning counselling services (for birth postponement or spacing) for this group could not be overemphasized.

20. The Expert Group expressed concern about the level of adolescent pregnancies. Precocious child-bearing continues to be a major impediment to improvement in the status of women. The social cost of adolescent fertility was high: it hindered possibilities for educational attainment and self-fulfilment and led to greater health risk. It was observed that the percentage of women under 20 giving birth was quite high in many developing countries. The actual number of teenage pregnancies was unknown because of the lack of statistics on abortion and miscarriages, but it was undoubtedly very high. There was ample evidence showing that much of this early child-bearing - whether within or outside marriage - was unwanted. High rates of unsafe abortion among adolescent women also attested to the issue of unwanted pregnancies. Adolescents were, in many countries, increasingly at high risk of contracting and transmitting sexually transmitted diseases (STDs), including HIV/AIDS, and they were often poorly informed about how to protect themselves. It was observed that many adolescents were sexually active and family planning programmes should be sensitive to their needs because they were the future users. The Group, therefore, emphasized the importance of involving youth in identifying their special needs and urged Governments to make provision for sex education, family-life education and HIV/AIDS education, and to ensure easy access to reproductive health services, including family planning services. In this regard, non-governmental organizations might play important partnership roles with Governments in developing innovative programmes for this segment of the population. The Group encouraged further research for better understanding of these adolescent concerns. In considering adolescent issues, the Group also focused on the related issue of abortion.

21. With regard to the issue of diffusion of innovative behaviour and information, education and communication (IEC) activities, the Expert Group noted that there was a substantial amount of unmet need for family planning; many women who wanted no more children and were exposed to the risk of pregnancy were not practising family planning. The intervention most suited to transforming these high levels of need into effective demand was information, education and communication activities. The Meeting also noted that two important aspects of IEC activities - research on development of IEC material, and management and evaluation of the dissemination process - often were neglected. There was much concern that IEC materials were designed on the basis of feelings rather than on research. It was also noted that IEC activities needed to be better managed, taking into consideration the existing IEC infrastructure, relevance of different IEC strategies, and the mixing of messages in appropriate media formats. Another important aspect that drew the attention of the Group was IEC activities targeted towards providers, policy makers and informal leaders. For the purpose of institutionalizing family planning in society, IEC programmes must identify the motivational needs of health-care providers, policy makers and informal leaders and must meet those needs; their support was essential for the effective implementation of programmes.

22. The Expert Group noted that community-based distribution (CBD) of contraceptives had played an important role in making contraceptives available to people living in areas not covered by commercial networks or institutional services. In a related area, social marketing of contraceptives (SMC) to low-income groups in developing countries had been met with mixed results. The impact of social marketing of contraceptives in terms of increased contraceptive

prevalence or fertility decline was still very uncertain, but undoubtedly it constituted a way to complement other supply channels. Both of these modes of delivery of supplies (CBD and SMC) had great potential which needed to be properly evaluated to determine their cost-effectiveness, scope of their contribution and extent to which subsidies were necessary. The question of combining these two approaches to reduce cost needed to be examined.

23. The future contraceptive requirements and logistic management needs of family planning programmes were considered at the Meeting. To achieve the United Nations medium-variant population projection by the year 2000, contraceptive prevalence in developing countries must rise from 51 per cent in 1990 to 59 per cent in 2000. This meant that an estimated 567 million couples must be using some form of contraceptive at the end of the century. According to this projection, the following would be needed in developing countries by the decade 1991-2000: 151 million surgical procedures for female and male sterilization; 8.76 billion cycles of oral pills; 663 million doses of injectables; 310 million IUDs and 44 billion condoms.

24. If the contraceptives required for the period 1991-2000 were purchased in the market, they would cost about US$ 5 billion. From an annual cost of US$ 399 million in 1990, the cost for contraceptives would rise to US$ 627 million by the year 2000. It should be noted that this total did not include the much larger cost of delivery of services. The total cost would vary according to the method-mix; for example, wider use of Norplant implant would increase costs considerably. It was projected that by the year 2000, Governments' share of the cost would be reduced from 60 per cent in 1990 to 52 per cent; private sector's share would remain the same, at 17 per cent, and international donors' share would rise to 31 per cent from 22 in 1990. Large though these sums were, the costs of contraceptive supplies constituted only about one fifteenth, or 7 per cent, of the total required by the year 2000 for supporting population activities, which was set at US$ 9 billion by the Amsterdam Declaration on a Better Life for Future Generations, adopted by the International Forum on Population in the Twenty-first Century.

25. Contraceptives were currently being manufactured locally in at least 23 developing countries and local production was under consideration in four or more countries. It was encouraging to note that in four large countries (Brazil, China, India and Indonesia), at least three methods (pills, condoms and IUDs) were produced locally with capacity approaching or exceeding their respective estimated commodity requirements. External assistance agencies had been active in supporting the local production of contraceptives.

D. Family planning and health

26. The Expert Group observed that the issue of safe motherhood should not be discussed in the context of health only, because motherhood was an important social function and not a disease. Rather, it should be considered in the wider context of the role and status of women. Women who wanted to avoid unwanted pregnancies should be provided with family planning services, including access to safe abortion, in order to protect their health and well-being. As family planning contributed substantially towards child survival and reduction of maternal mortality, the relevance of family planning in any strategy for safe

motherhood and child survival was undeniable. Another essential component of a safe motherhood strategy was good maternal care, which was not complete without preconception and post-partum care, in which birth planning was a basic component. In this connection, it was observed that progress towards safe motherhood should be measured in terms of lifetime risk of maternal death, and not in terms of the commonly used maternal mortality rate, which measured only obstetric risk. Equally important was the question of child survival, which was considered a desirable social goal in itself. Research evidence showed that family planning contributed substantially towards child survival. Women seeking preventive and promotive care for their children should have easy access to family planning care. The Group was of the opinion that reproductive health care should be provided as an integrated package of services that were mutually strengthening, cost-effective and convenient to users. An important point to note in this respect was that users should be the ones to determine the type of integration that was most suitable for their needs.

27. The Expert Group focused on the linkages between family planning, sexually transmitted diseases and AIDS. Family planning is practised by sexually active men and women of child-bearing age. The same are at risk of coming into contact with STD as well as heterosexually transmitted HIV infection. The practice of family planning should play a crucial role in the prevention of vertical transmission of HIV from mother to child, through prevention of pregnancy among HIV-infected women. Another important linkage between family planning and STDs/AIDS was that some of the contraceptive methods did have a protective effect against these infections. These important linkages implied the need to widen the scope of family planning programmes to encompass reproductive health care, including STD and AIDS control. Efforts to control these diseases could be enhanced by utilization of the widespread network of family planning clinics, especially in the rural areas of developing countries. The facilities offered unparalleled opportunity to reach women of child-bearing age when the risk of exposure to STD and AIDS was greatest. Integration of these services would permit optimal use of the limited resources available in the developing countries for the control of these infections as well as for family planning.

28. The obvious disadvantage of integration was that services might not reach men directly. This was an area requiring reorientation of the family planning approach, which had hitherto relied mainly on contact with women, to permit more interaction with men. For the purpose of integration, there was a need to initiate training activities for the personnel involved in family planning and STD/AIDS control services, aimed at making them realize the interrelationship between the services they offered and thereby promoting closer working relationships. The Meeting, however, cautioned about possible dangers of hasty integration. It could be an error to integrate STD-control programmes into existing family planning structures without making sure that current facilities could provide quality services, that adequate staff were present and that they had the necessary training and orientation. It was also necessary to encourage research in sexual behaviour in different cultural settings to provide information that could be used in intervention programmes. Finally, future research in contraceptive technology development should focus on methods that might have additional benefit in the prevention of STD/AIDS, and especially on those methods that were women-controlled.

E. Family planning and family well-being

29. Under the theme of family planning and family well-being, the Expert Group considered two important issues: (a) changes in family size and structure; and (b) fertility decline and family welfare systems. The Meeting recognized the importance of the family as a fundamental unit of society. The characteristics of the basic family types found in the East and in the West were discussed and compared. The families in the East were characterized by a "feedback model" of intergenerational relations, in which the older generation initially fostered the younger generation but was then cared for by the younger generation. The Western model was described as a "continued linear model", in which there was usually no feedback from the younger to the older generation. Consequently, the typical family pattern of Western society was the so-called nuclear family, consisting of husband, wife and unmarried children. In many Eastern societies, married children did not necessarily leave their parental home to form nuclear families and thus three-generation families were common in the East. The family size was, therefore, relatively larger than that of the West.

30. As elsewhere in East Asia, the traditional Chinese family had undergone substantial transformations in the past half century. Both family size and family structure had been affected by the process of modernization and by the profound structural changes experienced by the Chinese society. The average family size was 5.3 until the 1950s, it declined to 4.43 by the 1982 census and decreased further to 3.97 by the 1990 census. The decline in family size during the 1950s and the 1960s was mainly associated with social structural changes, such as land reform. By contrast, family-size reduction in the 1970s and the 1980s could primarily be attributed to fertility decline, although other factors such as improved housing supply and census underenumeration had also played a role. A process parallel to the decline in family size had been the trend towards family nuclearization. However, although the proportion of extended families had been decreasing substantially for the past five decades, the three-generation family still comprised about 20 per cent of Chinese families, and it was not certain that it would experience further reduction in the near future. Although there was no officially stated policy that promoted three-generation families, this family form had been viewed as beneficial for old-age care. However, the rapid fertility reduction would undoubtedly affect family structure in the coming years. When the children born under the current low-fertility regime reached the age of family formation, some elderly parents would not be able to live with married children, if they had only one married daughter, assuming that current cultural practices persisted. It was also noted that the policy, with respect to number of children a couple could have, led to large differences in fertility levels and family sizes between rural and urban areas, and between minorities and the Han majority. The Chinese case-study served as an illustration of how government policies, along with changing socio-economic conditions, affected the size and structure of the family. The attention of the Meeting was drawn to some undesirable consequences of the rapid fertility reduction experienced in the Chinese society: one child was sometimes raised as a "little emperor", with yet unknown consequences for the child's development, and a strict one-child policy might lead to sex-selective abortion practices. The impact of rapid decline in fertility on child development was not yet fully known.

31. Lower fertility levels resulting in smaller families were thought to benefit both parents and their children directly. This view assumed that decisions about family size and family welfare were made simultaneously at the start of child-bearing. In recent years, this conventional wisdom had been increasingly challenged. The Meeting, therefore, examined the linkages between reduced family size and family welfare systems, including the economic well-being of the family, welfare of the children, wife's employment opportunities, and parental old-age security. Whether the number of children was positively or negatively correlated with the economic well-being of the family would vary with the life-cycle stage of both the parents and the children, as well as the existing social settings. A study in a village in Bangladesh found that male children became net producers at age 12, and could compensate for their cumulative consumption by age 15. Similar results were found in northern Ghana. Other studies had shown that in a peasant society, at the aggregate level, the net worth of children was negative. A large family gained economic benefits from its size only at certain stages of the family life cycle. These studies, however, did not show the cumulative effect of actual family size on the economic well-being of the family. In a recent study in Thailand, where rapid socio-economic development was taking place, an assessment of the impact of a reduced number of children on family economic well-being was carried out by comparing couples whose reproductive years corresponded with the period of decline of fertility in Thailand but who had small and large families. The study found reduced family size to have positive effects on a couple's ability to accumulate wealth, participate in new forms of consumption and thus have more material possessions and better quality houses. In terms of welfare of the children, empirical evidence, from both developed and developing countries, showed a negative link between the educational attainment of the children and the size of the family. This relationship was also found to be true in Thailand. It was important to remember that, in the process of development, Thailand was experiencing rising costs of living and costs of raising children. Thai parents also had high aspirations for their children in terms of educational attainment. It could be said, therefore, that economic benefits were not the only guiding factors in family-size decisions. The nature of the linkages between fertility and women's employment varied according to a number of factors. Role incompatibility between reproduction and production was found to be stronger in urban areas as compared to rural areas. A recent study on parental care in Thailand showed that fertility decline did not significantly reduce the proportion of the elderly who would co-reside with an adult child. It was generally felt that there was a serious scarcity of research to explore the linkages between fertility decline and family welfare systems and this was an important area for future research.

F. Future directions: people's involvement in family planning programmes

32. In the 1960s, most of the public sector family planning programmes were centrally organized with a vertical delivery system and quantitative demographic targets rather than welfare goals. During the past 15 years, there has been an appreciable shift away from target-oriented vertical programmes. In its place, a growing concern has arisen that family planning services should be tailored to meet the needs and preferences of the clients who use them. The concept of "user's perspective" gradually came into prominence with the attendant emphasis

on community participation. In the early 1980s, community participation had received strong endorsement as a cornerstone of family planning programmes. At the Meeting, the recurrent themes of discussion included such issues as community participation, individual needs and preferences, quality of care rather than quantity, and the welfare aspect of programmes. All of these themes had direct or indirect bearing on community participation. The essential ingredient of the community participation concept was empowerment: the notion that communities should have a degree of control over the nature of development goals and implementation of activities. The participation of the community in planning, decision-making and programme implementation was its underlying and fundamental feature. The application of the concept in family planning had led to various forms of participation. Contributory participation, where communities assisted pre-set programmes by means of labour (volunteers), cash or provision of other resources such as land, was relatively common. The second most common form found was organizational participation, where formal or informal structures existed to facilitate contributions by the community. The limited empirical evidence suggested that genuine community participation in family planning in terms of "empowerment" was still extremely limited. The following reasons for this were discussed: family planning was perceived to be a need of a small fraction of the community; inflexibility of centralized programmes did not allow for local variations; family planning might lack a ready appeal to community elites, typically older men whose wives had passed beyond the reproductive age span; and family planning as an innovation might create antagonism based on religious beliefs, moral issues etc. Participatory programmes were often found in the private sector and they had met with relatively greater success, because non-governmental organizations tended to be more adaptable and accommodating to community wishes than were government departments. It was interesting to observe that, in the non-governmental organization programmes, integration was a common characteristic of community participation projects that involved family planning. It seemed reasonable to conclude that an integrated package of services with a decentralized programme development mechanism and the use of local institutions would ensure greater participation of the community in family planning and related activities, and would make family planning services more responsive to people's needs. However, the Group observed that it was also necessary to make serious objective evaluations of these activities, particularly in terms of cost-benefit analysis.

33. With regard to the cost of contraceptive supplies and services and cost-sharing, the evidence presented at the Meeting pointed to some important conclusions. First, the reproductive age cohort was increasing rapidly even as overall population growth declined. Simultaneously, donor resources were not expected to increase as rapidly as the increase of women/couples in the reproductive ages. Secondly, more works needed to be done to accurately measure the extent of the unmet need for contraceptives in the developing countries because available data were inadequate and measures were yet to be perfected. As a result, projections of unmet needs must be viewed as orders of magnitude. Thirdly, cost data were also troublesome because of the assumptions underlying them and the inaccuracy built into equating costs and expenditures. Determination of financial needs in the future, therefore, was complicated by the data limitations just mentioned. However, under the assumption that resources would be constrained in the future, efforts should be made to assess alternative financing arrangements and to improve resource allocation and efficiency of service delivery. Available evidence suggested that among the

countries that charged for family planning, fees were a small proportion of per capita GNP. Moreover, studies showed that upward adjustments to modest fees had little effect on utilization, indicating the possible scope for establishing or raising fees for family planning. In addition, third-party payers (e.g., insurance companies) for health care represented another potential financier to share costs with Governments and users. The Meeting had observed that cost and unmet need data deserved more consideration and more careful interpretation to guide decision-making processes to promote efficiency and appropriate targeting for subsidies. To promote cost-sharing, Governments must have better information on the price sensitivity of consumers. By removing impediments to private investment in family planning, Governments should encourage private sectors to expand their share of service delivery. Innovations in modes of delivery of family planning services were essential.

34. In the agenda item on contraceptive research and development, the Group reviewed the most important existing contraceptive methods with respect to safety and efficiency, emphasizing their effects on women's reproductive health. The Meeting noted that women in their different life-cycle stages had different needs for different types of contraceptive methods. The current research agenda on contraceptive methods included the relation between hormonal methods and neoplasia, barriers methods for protection against STD/HIV, breast-feeding and contraceptive methods, and the use of modern IUDs with high efficiency and few side effects. Through the collaboration between national and international agencies and non-governmental organizations, promising research was continuing on anti-fertility vaccines, methods for the regulation of male fertility and antiprogestins for early pregnancy termination. Research needs were identified which would be critical in the future. In the light of this review and discussion, a few conclusions were reached at the Meeting. First, there had been a general decline in expenditures on research in fundamental reproductive physiology, new contraceptive methods and safety evaluation. Secondly, there had been a large reduction in the involvement of pharmaceutical companies in contraceptive research for various reasons: belief that the market was already "mature"; the long time required to develop a new method, and the even longer period before there was any return on investment; and the regulatory problems imposed by drug administrations and the legal liabilities. To encourage future research in new contraceptive methods, these barriers needed to be removed. Thirdly, non-governmental organizations had an important role to play in contraceptive research by creating a global partnership of scientists who would work together in the development of new methods, thus filling the gap left by Governments and the commercial sector. Fourthly, there should be an emphasis in research on new methods for men.

35. In re-examining the role of Governments, non-governmental organizations and the private sector in family planning, the Meeting observed that, despite recent progress in family planning, there were still many challenges, including a growing demand for services. Governments must at least sustain, or increase, support for family planning and try to remove legal and other barriers to expanding services. They should aim to be flexible, recognizing the needs of adolescents, and replicate successful models of service delivery. The existing role of non-governmental organizations in innovative service delivery should be extended to offer appropriate reproductive and sexual health services to those most in need, to improve the quality of care and community involvement, to demonstrate cost-effectiveness and address women's concerns. Non-governmental

organizations still had an advocacy role, particularly to reduce unsafe abortions and to increase services for young people. The private sector must cooperate with Governments and non-governmental organizations, price contraceptives for retail distribution on the basis of the price sensitivity of consumers, and participate in community-based distribution and social marketing.

II. RECOMMENDATIONS

A. Preamble

36. The World Population Plan of Action, adopted by consensus at the World Population Conference, held at Bucharest in 1974, affirms that all couples and individuals have the basic right to decide freely and responsibly the number and spacing of their children and to have the information, education and means to do so. This right should be assured in all countries, irrespective of their demographic objectives.

37. The use of safe and appropriate fertility regulation methods has immediate benefits for the health, well-being and autonomy of women. Family planning also promotes the health and welfare of children, adolescents and men, and the well-being of the family as a unit. Finally, family planning contributes to achieving other societal goals such as the advancement of women, improvements in overall health status, the stabilization of population growth, preservation of the environment, sustainable economic and social development, and the overall quality of life. Indeed, as stated in the report of the United Nations Children's Fund, State of the World's Children, 1992, the responsible planning of births is one of the most effective and least expensive ways of improving the quality of life on Earth, both now and in the future, and one of the greatest mistakes of our times is the failure to realize this potential.

38. Empirical evidence reaffirms strong linkages between socio-economic development and fertility trends. Family planning programmes tend to be most successful where social and economic conditions encourage the adoption of small family norms. Recent experience, however, has demonstrated that even in poor socio-economic conditions, considerable desire to regulate family size exists and fertility has fallen in countries with well-organized programmes. Individuals in all settings should not be denied access to the information and means to regulate their fertility and improve the quality of their lives.

39. In the past two decades, a reproductive revolution has occurred. Countries have made dramatic progress in expanding the availability of family planning services, increasing the use of contraception and accelerating the pace of fertility decline beyond that which would have occurred in the absence of services. Based on data for women of reproductive age, 53 per cent of couples are now estimated to be using contraception; however, there are enormous disparities in levels of contraceptive use between regions. The availability of family planning services has itself contributed to a dramatic downward adjustment of desired family size in many countries. In the less developed regions, where fertility has been the highest, total fertility rates have declined from approximately 6.1 in the 1950s to close to 3.7 currently.

40. Despite this progress, major challenges remain. As a consequence of earlier high fertility in the developing countries, more and more men and women are entering their reproductive years, and the need for family planning services in these countries will therefore continue to increase rapidly. During the decade of the 1990s, just to maintain current levels of contraceptive use, approximately 100 million more couples will need family planning services. If fertility declines according to the medium variant of the United Nations population projections, then a further 75 million couples will need access to family planning information and services by the year 2000.

41. In addition, large disparities remain both within and among countries in the practice of family planning. Socio-cultural, economic and other institutional constraints often prevent couples and individuals from making informed decisions concerning child-bearing. Millions of men and women of reproductive age in both the developed and the less developed regions still do not have access to safe and effective methods of fertility regulation, as well as information on how to use them. In many countries, these conditions are reflected in high abortion rates.

42. The adoption of family planning has contributed to safe motherhood and child survival. However, the death and suffering of women in fulfilling their child-bearing responsibilities continues to be a major scandal. Each year more than 500,000 women lose their lives for causes related to pregnancy and childbirth. There has been very little progress towards the goal of reducing maternal mortality by one half by the year 2000. Avoiding unwanted pregnancies and proper planning of births lowers maternal mortality. However, safe motherhood will only be achieved through concerted national and international efforts to make quality maternal health services, including safe abortion, readily accessible to all women. This should be a high priority for the next decade.

43. The quality of family planning services is also uneven. A major challenge in the coming decade will be to expand currently available contraceptive choices for individuals in many countries and to improve the interpersonal skills and technical competence of family planning providers. There is also an urgent need to develop new and improved contraceptive methods.

44. The revolution in contraceptive technology has stalled because of the inadequate allocation of resources and the retrenchment of the pharmaceutical industry. Concerted efforts are needed to launch a second revolution in contraceptive technology to provide a new generation of contraceptives for the twenty-first century.

45. One of the most serious problems of the coming decade is the spread of the AIDS pandemic, which jeopardizes the well-being of mankind. Family planning programmes have an important role to play in the prevention of HIV.

46. The Expert Group Meeting on Family Planning, Health and Family Well-being, having reviewed the progress made in achieving the goals and objectives of the World Population Plan of Action, adopted the following recommendations, which are intended to reaffirm as well as extend or update previous recommendations adopted by Governments in various international forums. They seek to identify actions that Governments can take to support couples and individuals in making

informed and voluntary choices about the timing, number and spacing of children, through family planning programmes and other social policies. Because these issues are of global concern, the recommendations are also addressed to intergovernmental and non-governmental organizations as well as to the donor community.

B. Recommendations

Recommendation 1

Governments are invited to note the growing evidence that all individuals and couples, regardless of their socio-economic status, value the opportunity to space and limit their families, and that family planning can be promoted successfully where levels of socio-economic development are low, provided that the design of services takes into account the socio-cultural setting. Family planning programmes should be regarded as a cost-effective component of a broader development strategy, one that has significant independent effects on family well-being and individual and social welfare, particularly of women.

Recommendation 2

Governments should strive to develop social and political institutions and norms that are oriented towards providing women opportunities, through formal and informal education, for personal development and greater autonomy both within the family and the society as a whole. Governments should support the involvement of women at all levels of the public policy process and especially in the design, management, implementation and evaluation of social welfare, health and family planning programmes.

Recommendation 3

Recognizing the fundamental role of the family in reproduction and in the socialization of future generations, Governments are urged to support the family through public policies and programmes, taking into consideration changes in family forms, size and structure. Governments should promote family life education for responsible parenthood for both men and women, high quality child-care arrangements to enable individuals to combine their dual roles as parents and workers, and adequate support for the children of single parents.

Recommendation 4

To save the lives of mothers, children and adolescents and to improve their general health, Governments and the international community are urged to increase their investment in family planning and reproductive and maternal and child health (MCH) services. Governments are also urged to monitor the progress in safer motherhood and child survival and to take the necessary actions to enhance the effectiveness of the interventions.

Recommendation 5

Governments and donors are urged to increase their support to the social sectors, foremost among them health and education, to a level where basic human rights in these areas can be satisfied.

Recommendation 6

Governments and intergovernmental and non-governmental organizations are urged to recognize that abortion is a major public health concern and one of the most neglected problems affecting women's lives. Women everywhere should have access to sensitive counselling and safe abortion services.

Recommendation 7

Given the high prevalence of sexually transmitted diseases and the AIDS pandemic, which threatens the well-being of men, women and children, family planning programmes need to widen their scope to include reproductive health care, including STD/HIV education and prevention.

Recommendation 8

Political leaders at all levels should play a strong, sustained and highly visible role in promoting and legitimizing voluntary adoption of family planning, and in ensuring a legal and regulatory climate that is favourable for the expansion of family planning services of high quality. National and local leaders should translate their commitment to family planning into the allocation of substantially increased budgetary, human and administrative resources required to meet the increasing demand for services.

Recommendation 9

Family planning programmes at both the national and the local level should seek to increase awareness of the importance of family planning and commitment to the expansion of good quality family planning services on the part of key influence groups, including the media, women's and voluntary organizations, local and religious leaders, and the private business community. The involvement of non-governmental groups in these advocacy efforts, wherever feasible, may greatly facilitate the process of consensus and coalition-building in support of family planning efforts.

Recommendation 10

Family planning programmes should aim to help individuals to achieve their reproductive goals, and should be based on voluntary, free and informed choice.

Recommendation 11

Governments should establish family planning goals on the basis of the unmet demand and need for information and services. Demographic goals, while legitimately the subject of government policies and programmes to achieve sustainable development, should not be imposed on family planning providers in the form of targets or quotas for recruitment of clients. Family planning

services should be framed in the context of the needs of individuals, especially women. Over the long term, meeting unmet needs appears to be the best strategy for achieving national demographic goals.

Recommendation 12

At the national level, the major institutions involved in family planning should periodically undertake a systematic examination of the strengths and weaknesses of family planning efforts, including the competence of national and regional managers. This process should include an assessment of how major programme elements are contributing cost-effectively to overall goals, and result in the development and implementation of coordinated strategies for programme improvement.

Recommendation 13

Family planning programme managers should consult with and encourage the participation of local community groups in the design, financing and delivery of family planning services, wherever feasible. Promising strategies for increasing community participation include the following: increased involvement of social organizations such as men's, women's and youth groups, cooperatives and religious organizations and the use of local volunteers; greater decentralization of decision-making to local administrative structures that are better placed to respond to community needs; and increased pluralism of institutions in the delivery of services.

Recommendation 14

Governments and non-governmental organizations are urged to improve the quality of family planning services by incorporating the user's perspective and respect for the dignity and privacy of the client. Programmes should provide the broadest possible range of contraceptive methods; thorough and accurate information to enable clients to make informed choices; systematic follow-up; easy availability of and accessibility to services; and technically competent service providers who receive proper training and supervision, with additional emphasis on communication and counselling skills. Unnecessary medical and regulatory barriers restricting access to services should be removed. Strategies should be carefully designed and tailored according to local conditions, and the cost of services and contraceptives should be subsidized for people who cannot afford the full cost.

Recommendation 15

Governments, donors and non-governmental organizations are encouraged to increase the provision of family planning services through multiple channels to unserved and underserved populations, such as adolescent, minority, migrant and refugee groups. Effective outreach approaches include promotional activities, community-based strategies, and local health and commercial networks.

Recommendation 16

Governments are urged to recognize the special needs of the young and adolescent population and to strengthen programmes to minimize the incidence of

high-risk and unwanted pregnancies and STD/HIV infection. Special efforts need to be made to reach this target population with information, education and motivational campaigns through formal and informal channels, including the involvement of young people themselves. In view of the fact that adolescents tend to avoid or underutilize MCH/family planning and STD services, often with disastrous consequences, it is important that service providers be trained to be more receptive to adolescents, and that legislation not inhibit the use of services by adolescents. Programmes should provide confidential services to adolescent men and women without regard to marital status or age. Young people should be involved in the planning, implementation and evaluation of programmes designed to serve them in order for services to be sensitive to their needs.

Recommendation 17

Governments, donors and non-governmental organizations are called upon to provide resources for social marketing of contraception in order to create a demand for family planning services, especially in underserved areas and among traditional communities and population groups where demand is low or non-existent. Emphasis should be placed on using consumer-oriented approaches such as careful targeting and segmentation of unserved populations, proper design of education and communication strategies based on research, and an appropriate mix of media and interpersonal communications.

Recommendation 18

Governments, donors and non-governmental organizations should encourage greater involvement in and responsibility for family planning on the part of men, through research on male attitudes and motivation, messages specifically tailored for men, strategies to encourage responsible fatherhood, sharing of responsibilities between men and women, research on male methods of contraception, and innovative clinical services adapted to the needs of men.

Recommendation 19

Governments and non-governmental organizations are encouraged to support information, education and communication (IEC) activities in order to increase awareness of the benefits of family planning for both individuals and the larger community, through comprehensive education efforts utilizing a wide variety of communications channels. Such programmes have played a crucial role in bringing about the transformation of traditional attitudes and social behaviour necessary for the adoption of modern contraception. Public education programmes should develop a clear communications strategy based on empirical research on social values and reproductive behaviour.

Recommendation 20

Governments and education administrators are called upon to expand and strengthen population and family life education at all levels of formal education as well as literacy programmes. Such programmes should be designed to help children and youth in making informed decisions regarding their sexual behaviour, responsible parenthood and family planning. Special emphasis should be placed on training teachers and developing relevant communication methodologies.

Recommendation 21

Governments and international organizations are urged to increase their support to non-governmental organizations working in family planning, particularly in two ways. First, by facilitating the development of public/non-governmental organization partnerships aimed at expanding access to family planning services. Secondly, by supporting these organizations to address in innovative ways such important issues as the reproductive health of adolescents, women's empowerment, community participation, broader reproductive health services, quality of care and outreach to marginalized groups. Once shown to be effective and acceptable, new approaches can then be integrated into wider national family planning programmes.

Recommendation 22

Non-governmental organizations are encouraged to coordinate their activities at the national and international level and to continue to emphasize their areas of comparative advantage, including voicing to policy makers the real concerns and needs of women and local communities regarding sexual and reproductive health.

Recommendation 23

Governments should identify and remove legal and regulatory barriers that impede private sector involvement in family planning, including regulations that constrain contraceptive options; tax and importation policies; advertising and promotion restrictions; patent and trade mark laws; pricing policies; and restrictions on fees charged by non-profit organizations.

Recommendation 24

Governments and non-governmental organizations should support public/private partnerships aimed at expanding access to family planning services. Such arrangements include financing private services through insurance or other third-party mechanisms, and facilitating commercial enterprises to provide family planning as part of the health benefit plans provided to employees. Public sector programmes should seek to complement the existing family planning activities of the private non-profit and commercial sectors, including private health-care providers.

Recommendation 25

Governments, non-governmental organizations and donors are urged to improve forecasting of contraceptive requirements based not only on current use but also on plans for future programme directions and priorities. Increased efforts must be directed at coordinating planning for contraceptive needs, putting systems in place that minimize the need for emergency responses, as well as helping countries to reduce their reliance on donors.

Recommendation 26

In meeting future contraceptive requirements, the partnership between the public and the commercial sectors should be strengthened. The role of the

commercial sector should be expanded in producing, procuring and delivery of contraceptives.

Recommendation 27

National Governments and international and non-governmental organizations are called upon to provide additional resources for family planning in order to satisfy the rapidly increasing demand for services. With a view to reaching the United Nations medium-variant population projections, the cost of contraceptive commodities alone has been estimated at US$ 627 million in the year 2000. The associated logistics, management and service delivery costs are likely to increase this figure as much as tenfold.

Recommendation 28

In order to better address the quantity of resources required, further work is needed to estimate all the component costs of family planning programmes. At the same time, more attention must be paid to cost-effectiveness, efficiency, cost-recovery, cost-subsidization, community-resource mobilization, local production of contraceptives, where appropriate, and other mechanisms to ensure the optimum use of existing resources, thereby lowering costs, targeting subsidies and promoting financial solvency.

Recommendation 29

Governments of developed and developing countries and intergovernmental organizations are thus urged to increase significantly their proportions of development assistance for family planning to meet resource requirements. In so doing, it should be noted that costs of programmes and sources of financing will vary by such factors as social and economic setting, programme maturity, programme coverage and delivery modes, including the extent of involvement of the private and non-governmental sectors.

Recommendation 30

Governments and donors are urged to increase support for research on improving existing contraceptive technology as well as developing new technology that will be affordable in developing countries, focusing on methods that may have additional benefits in the prevention of STD/AIDS, male methods to increase men's involvement in family planning, and methods appropriate for breast-feeding women. Efforts should be made to remove constraints hindering progress in this area, including inappropriate litigation practices and unjustified regulatory requirements, and to enhance the involvement of private industry in this effort.

Recommendation 31

Governments and donors are encouraged to support social science research on human sexuality and sexual behaviour in different cultural settings to provide information useful in intervention programmes to prevent unwanted pregnancies and STD/HIV infections.

Recommendation 32

In order to improve the efficiency of the limited resources available for family planning programmes, Governments and donors are urged to support field studies at the subnational level in different cultural settings to ascertain the relative cost-effectiveness of various approaches.

Recommendation 33

Governments, non-governmental organizations and donors are urged to support ongoing applied research efforts in family planning. Special emphasis should be given to evolve definition, standards and indicators of quality of services appropriate to a country/programme setting; and to include quality of service in the description, monitoring and evaluation of family planning programmes.

Recommendation 34

In view of the importance attached to the role of family planning programmes in enabling individuals to achieve their reproductive goals, Governments and donors should support research efforts to develop indicators of programme performance to capture this crucial dimension.

Recommendation 35

Governments are urged to attach higher priority to the utilization of available data and information for programme planning and implementation; to the collection of timely and reliable data and information, especially on cost; and to the strengthening of human resources in various countries in order to facilitate data collection, analysis and utilization for programme planning and implementation.